IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER, GOVERNOR
RICHARD M. ARMSTRONG, DIRECTOR

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BUREAU OF FACILITY STANDARDS
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June 1, 2009

Rex Redden
Idaho Falls Group Home #3 Periska
P.O. Box 50457
Idaho Falls, ID 83405-0457

RE: Idaho Falls Group Home #3 Periska, provider #13G045

Dear Mr. Redden:

This is to advise you of the findings of the Medicaid/Licensure survey of Idaho Falls Group Home #3 Periska, which was conducted on May 21, 2009.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **June 15, 2009,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by June 15, 2009. If a request for informal dispute resolution is received after June 15, 2009, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

Michael A. Case, LSW

MICHAEL A. CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/mlw

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G045	A. BUILDING _____ B. WING _____	05/21/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #3 PERISKA	950 PERISKA WAY IDAHO FALLS, ID 83405

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W 000	INITIAL COMMENTS The following deficiencies were cited during your follow up survey. The surveyors conducting your survey were: Michael Case, LSW, QMRP, Team Leader Jim Troutfetter, QMRP Common abbreviations used in this report are: ITTP - Interdisciplinary Treatment Team Plan NOS - Not Otherwise Specified QMRP - Qualified Mental Retardation Professional	W 000	RECEIVED JUN 17 2009 FACILITY STANDARDS	
W 152	483.420(d)(1)(iii) STAFF TREATMENT OF CLIENTS The facility must prohibit the employment of individuals with a conviction or prior employment history of child or client abuse, neglect or mistreatment. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure employees received a thorough background check, which had the potential to negatively impact 6 of 6 individuals (Individuals #1 - #6) residing in the facility. That failure had the potential to allow staff with prior convictions of abuse, neglect or mistreatment to work with individuals residing at the facility. The findings include: 1. The facility's "Policy for Background Check Completion," revised 7/15/08, outlined the facility's procedure for completing self declarations and criminal background checks. A	W 152	W 152 1. All individuals have the potential to be affected by this practice. A Human Resource position has been implemented to ensure background checks are being scheduled and that employees are attending the appointments. A form has been created which indicates the employee's date of hire, the date the background check was scheduled for, the date the background check was completed, the date the clearance letter was printed, and the date the clearance letter was filed in the employee file. The Background Check Policy will be revised to include and/or delete all changes made to the background check procedure. 2. The Human Resource employee will be responsible for monitoring the background check procedure. The QMRP will complete a weekly follow-up with the Human Resource employee and will initial and date the form that has been created to indicate that follow-up has been completed. 3. Target date for completion will be July 21, 2009.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Andrea Bolt	Admin. Designee	6/12/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 152	Continued From page 1 review of the facility's personnel records documented the following concerns: a. The Policy stated employees were to attend an orientation class within the first 7 days of employment at which time a self declaration and application for a fingerprint based criminal history check was to be completed. The policy stated "all copies of the Self Declaration will be signed and notarized before it goes into the file." - Staff A's personnel file documented she was hired 2/20/09. Her personnel file contained two self declaration and applications for fingerprinting, dated 2/26/09 and 3/5/09. However, both self-declarations and applications were unsigned and un-notarized. - Staff B's personnel file documented he was hired 1/13/09. However, his personnel file included an unsigned and un-notarized self declaration and application for a background check. - Staff C's personnel file documented he was hired 11/25/08 and was terminated on 1/21/09. However, his personnel file included an unsigned and un-notarized self declaration and application for a background check. - Staff E's personnel file documented he was hired 12/6/08. However, his personnel file did not include a self declaration and application for a background check. - Staff F's personnel file documented she was hired 3/1/09. However, her personnel file did not include a self declaration and application for background check.	W 152		

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W 152	Continued From page 2 Without completion of the initial screening steps of signing a self declaration and application for a background check, the facility would not be able to ensure persons with disqualifying convictions were precluded from working. The facility failed to ensure staff completed, signed, and had notarized a self declaration and application for background check. b. The Policy stated an appointment to be fingerprinted would be made at the time the staff completed the self declaration and application for a background check. The Policy stated "If the employee then misses his/her appointment they will be put on suspension until they reschedule the fingerprinting and have completed their fingerprinting." - Staff A's personnel file documented she was hired 2/20/09. Her personnel file contained two self declaration and applications for fingerprinting, dated 2/26/09 and 3/5/09. Additionally, her personnel file documented she missed fingerprinting appointments for both applications. However, the facility's as worked schedule documented Staff A worked continually from her hire date until she completed fingerprinting on 4/21/09. The facility failed to ensure Staff A was suspended from working with individuals following her missed fingerprinting appointments. c. The Policy stated "Weekly checks of the manual will be done by the Administrator Designee to ensure follow up is happening for the applications. Follow up will occur weekly until a	W 152		

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W 152	Continued From page 3 clearance letter or denial letter is received from the Department." There was no documentation weekly checks had been completed. Without a review process being implemented, the facility would not be able to identify and correct issues with missed appointments and failure to complete applications. That failure created the potential for persons with disqualifying convictions to work with individuals residing at the facility. When asked during an interview on 5/20/09 from 1:15 - 1:20 p.m., the Administrator stated the reviews had not been taking place due to an oversight. During an interview on 5/21/09 from 9:30 a.m. - 12:30 p.m., the QMRP stated the facility's Policy for Background Check Completion was not being followed as written. The facility failed to ensure all staff received thorough screening for staff to prohibit the employment of individuals with convictions or prior employment histories of child or client abuse, neglect or mistreatment.	W 152		
W 312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was	W 312		

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W 312	Continued From page 4 determined the facility failed to ensure behavior modifying drugs were used only as comprehensive part of the individuals' ITTPs that were directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs were employed for 1 of 3 individuals (Individual #1) whose medication reduction plans were reviewed. This resulted in an individual receiving behavior modifying drugs without plans that identified the drugs usage and how they may change in relation to progress or regression. The findings include: 1. Individual #1's 8/28/08 ITTP stated he was a 40 year old male whose diagnoses included severe mental retardation, chronic depression, and Organic Brain Syndrome with psychosis and aggression. His Physician's Orders, dated 5/2/09, stated he received Celexa (an antidepressant drug) 20 mg daily and Mellaril (an antipsychotic drug) 200 mg daily. Individual #1's Medication Reduction Plan, dated 8/28/08, stated he received Celexa and Mellaril for "the diagnosis of Organic Brain Syndrome with Psychosis and aggressive features and chronic depression with features of Obsessive Compulsive behaviors." The Medication Reduction Plan listed the following criteria for reduction: - Aggressive behavior (hit, kick, or throw items) 4 or less times per month for 12 consecutive months. - Initiate requested activities with 95% accuracy per month for 12 consecutive months. - Ten or fewer symptoms of depression per month for 12 consecutive months.	W 312	W 312 1. All individuals have the potential to be affected by this practice. The QMRP has contacted the psychiatrist for clarification on which medications are tied to which behavior symptoms. The medication reduction plan has been revised to indicate the psychiatrists recommendations for which medications are tied to which behaviors, diagnoses, and symptoms for which they are prescribed. The medication reduction plan has also been revised to indicate which objective must be met prior to a reduction being attempted. 2. The QMRP will be responsible for monitoring behavioral objectives monthly. If criteria is met on the behavioral objective that is tied to the medication reduction plan, a recommendation for a medication reduction will be made to the individuals treatment team and psychiatrist. If criteria is met on the behavioral objective, the medication reduction plan will be reviewed and revised as needed. 3. Target date for completion will be July 21, 2009.	

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W 312	Continued From page 5 Individual #1's Medication Reduction Plan stated Celexa would be reduced first followed by Mellaril. However, it was not clear which of the three criteria had to be met, or if all three criteria had to be met prior to a reduction being attempted. Additionally, it was not clear which medication was tied to which behavior or symptoms (i.e., Celexa tied to depressive symptoms, Mellaril tied to aggressive symptoms, etc.) or if both medications were tied to all symptoms. When asked during an interview on 5/21/09 from 9:30 a.m. - 12:30 p.m., the QMRP stated the criteria on the Medication Reduction plan should not be combined and the medications were not clearly linked to the diagnoses and symptoms for which they were prescribed. The QMRP stated Individual #1's Medication Reduction Plan needed to be revised. The facility failed to ensure drugs used to control Individual #1's maladaptive behaviors were clearly incorporated into a plan.	W 312		
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure all drugs were administered without error for 1 of 4 individuals (Individual #3) who were observed to take medications. This resulted in an individual receiving the wrong medication dose at the wrong time. The findings include:	W 369		

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W 369	Continued From page 6 1. Individual #3's 10/2/08 ITTP stated he was a 47 year old male whose diagnoses included profound mental retardation, intermittent explosive disorder, impulse control disorder NOS, and Autism. His Physician's Orders, dated 5/2/09, stated he received Lithium (a central nervous system drug) 300 mg each morning and 900 mg each evening. During an observation on 5/19/09 from 6:30 - 8:45 a.m., Individual #3 was observed to punch three pills from a blister pack into a medication cup and swallow the pills. The blister pack was marked "Lithium Carbonate 300 mg" and stated Individual #3 was to receive 1 tablet each a.m. and 3 tablets each p.m. The blister pack had a sticker on the upper right had corner that stated "AM." Individual #3's Medication Administration Record, dated 5/09, stated Individual #3 was to receive Lithium Carbonate 300 mg 1 tablet each a.m. and 3 tablets each p.m. When asked, the staff completing the drug pass stated the number of pills did not match the Medication Administration Record. The staff contacted the facility's Medical Coordinator. During an interview on 5/21/09 from 9:30 a.m. - 12:30 p.m., the Medical Coordinator stated Individual #3's blister packs for Lithium Carbonate had been incorrectly marked by the pharmacy with the "AM" and "PM" stickers. As a result, Individual #3 had been receiving 900 mg of Lithium Carbonate in the a.m. and 300 mg in the p.m. rather than as prescribed. The Medical Coordinator stated the error should have been noted when the medications were delivered from the pharmacy.	W 369	W 369 1. All individuals have the potential to be affected by this practice. All blister packs and medication flow sheets will be double checked for accuracy once they have been delivered from the pharmacy. 2. The Medical Coordinator and Health Care Assistant will be responsible for double checking the blister packs and medication flow sheets for accuracy once they have been delivered from the pharmacy. If any errors are found on the blister packs or medication flow sheets, the Medical Coordinator will immediately notify the pharmacy to correct the errors. 3. Target date for completion will be July 21, 2009.	

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W 369	Continued From page 7 The facility failed to ensure Individual #3 received the correct dose of Lithium Carbonate at the correct time.	W 369		
W 376	483.460(k)(8) DRUG ADMINISTRATION The system for drug administration must assure that drug administration errors and adverse drug reactions are reported immediately to a physician. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure all medication errors were reported immediately to a physician for 1 of 4 individuals (Individual #3) who were observed to take medications. This resulted in the physician being unaware an individual received the wrong medication at the wrong time until the following day. The findings include: 1. Individual #3's 10/2/08 ITTP stated he was a 47 year old male whose diagnoses included profound mental retardation, intermittent explosive disorder, impulse control disorder NOS, and Autism. His Physician's Orders, dated 5/2/09, stated he received Lithium (a central nervous system drug) 300 mg each morning and 900 mg each evening. During an observation on 5/19/09 from 6:30 - 8:45 a.m., Individual #3 was observed to receive 900 mg of Lithium Carbonate rather than 300 mg as ordered. The staff completing the medication pass immediately contacted the Medical Coordinator to report the incident. When asked during an interview on 5/21/09 from	W 376	W 376 1. All individuals have the potential to be affected by this practice. The Medication Error Policy will be revised to indicate the steps that are to be taken if a medication error occurs. A form has been created to document medication errors as well as nursing follow-up. The form also includes a place to document the date and time the physician was notified of the medication error. 2. The Medical Coordinator will be responsible for following-up on all medication errors. The Medical Coordinator will also be responsible for notifying the physician as well as documenting that notification occurred. 3. Target date for completion will be July 21, 2009.	

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W 376	Continued From page 8 9:30 a.m. - 12:30 p.m., the Medical Coordinator stated she did not notify the physician of the medication error until 5/20/09. The facility failed to ensure the medication error involving Individual #3 was immediately reported to the physician.	W 376		
W 455	483.470(I)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure there was an active program for the prevention and control of communicable diseases. This failure directly impacted 3 of 3 individuals (Individuals #1, #3, and #4) observed at the facility's day treatment program, and had the potential to impact 6 of 6 individuals (Individuals #1 - #6) who resided at the facility by providing opportunities for cross-contamination to occur between individuals and negatively impact their health. The findings include: 1. During the entrance conference on 5/18/09 from 11:30 a.m. - 12:25 p.m., the QMRP stated all six individuals residing at the facility attended the facility's day treatment program. An observation was conducted at the facility's day treatment program on 5/19/09 from 9:50 - 10:45 a.m. During that time, the following concerns were noted in the room attended by Individual #1, Individual #3, and Individual #4:	W 455	W 455 1. All individuals have the potential to be affected by this practice. All employees will be retrained on infection control practices, policies and procedures. 2. The supervisor of each facility will be responsible for immediately retraining all employees on infection control, prevention, and investigation of infection and communicable diseases. The supervisor of each facility will be responsible for providing on-going training to all employees on infection control practices, policies and procedures during their monthly staff meetings. 3. Target date for completion will be July 21, 2009.	

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W 455	Continued From page 9 - Individual #1 was noted to have a runny nose. During the observation, a staff member repeatedly assisted Individual #1 to wipe his nose, then assisted other individuals, including Individual #3, with tasks without washing or sanitizing her hands. Additionally, the staff member provided edible reinforcements to no less than 3 other individuals in the room. Those reinforcements were located in her pocked in a plastic bag, and in a cabinet in a plastic bag. The staff would remove the reinforcements with her bare hands and provide them to the individuals. - Staff provided Individual #1 with a stack of washcloths, which he folded. Individual #1's nose was noted to run continually during the task. Once Individual #1 had folded the washcloths, the staff placed the items on a shelf. A second staff removed the washcloths and provided them to an individual from another facility to fold. - An individual from a different facility was observed to be working with a packaging project. The individual was noted to repeatedly place his hand in his pants and scratch his buttocks, as well as scratch his nose. The individual would then touch the items to be packaged and place them in their appropriate containers. When the individual finished the task, a staff placed the items on a shelf. Another staff removed the same items and provided them to Individual #3 to sort and package. The staff did not sanitize the items prior to providing them to Individual #3. Upon completion of the task, the items were then passed to Individual #4. The items were not sanitized prior to being provided to Individual #4. - An individual from a different facility was observed to be placing lids of varying size on	W 455		

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W 455	Continued From page 10 containers. During the course of the task, the individual would place the lids or containers against his mouth. Upon completion of the task, the staff gathered the items and provided them to Individual #3. The items were not sanitized prior to being provided to Individual #3. - A staff was observed to have a ball-point pen in her hair. The staff would repeatedly remove the pen from her hair to document activities in the room, and then replace the pen in her hair, touching her hair repeatedly in the process. The staff was not observed to wash or sanitize her hands during the course of the observation. The staff was observed to provide multiple edible reinforcements to individuals within the room with her bare hands. - A second staff was observed to repeatedly use her hands to sweep her hair behind her ears. The staff was not noted to wash or sanitize her hands during the course of the observation. The staff was noted to handle items individuals had been manipulating and placing in their mouths, pass the items to other individuals, and provide edible reinforcements to individuals within the room. When asked about infection control practices, the two staff present during the observation stated staff were trained to wash and sanitize individuals' hands, and desks, tables and chairs were wiped down with bleach solution each night. When asked about the practices observed, staff stated they should have washed or sanitized their hands while working with individuals, and should have sanitized items prior to providing them to other individuals. Both staff stated they had not realized items were being placed in individuals'	W 455		

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IDAHO FALLS GROUP HOME #3 PERISKA	950 PERISKA WAY IDAHO FALLS, ID 83405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 455	Continued From page 11 mouths, and did not think about washing their own hands prior to touching edible reinforcements. The day treatment Supervisor, who was present during the observation, stated items should have been sanitized and staff should have been washing their hands frequently. The Supervisor stated more training needed to be completed. The facility failed to ensure infection control practices, including hand washing and sanitization of activity items, were implemented at the day treatment program. 2. During an observation at the facility on 5/18/09 from 5:30 - 6:45 p.m., Individual #4 was observed to be wearing finger-less cloth biking gloves while eating dinner. When staff was asked what the gloves were for, the staff stated Individual #4 used them for protection of her hands when pushing her wheelchair. Without removing the gloves to eat, it was not clear how staff could ensure Individual #4's hands were properly washed, or to ensure contaminants on her gloves were not coming into contact with her food. When asked during an interview on 5/21/09 from 9:30 a.m. - 12:30 p.m., the QMRP stated Individual #4 should not have been wearing the gloves while eating. The facility failed to ensure infection control procedures were implemented.	W 455		

Bureau of Facility Standards

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MM066	16.03.11009 Criminal History and Background Check 009.CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS. 01. Criminal History and Background Check. An intermediate care facility for the treatment of individuals with mental retardation must complete a criminal history and background check on employees and contractors hired or contracted with after October 1, 2007, who have direct patient access to residents in the intermediate care facility. A Department check conducted under IDAPA 16.05.06, " Criminal History and Background Checks, " satisfies this requirement. Other criminal history and background checks may be accepted provided they meet the criteria in Subsection 009.02 of this rule and the entity conducting the check issues written findings. The entity must provide a copy of these written findings to both the facility and the employee. (3-26-08) 02. Scope of a Criminal History and Background Check. The criminal history and background check must, at a minimum, be a fingerprint-based criminal history and background check that includes a search of the following record sources: (3-26-08) a. Federal Bureau of Investigation (FBI); (3-26-08) b. Idaho State Police Bureau of Criminal Identification; (3-26-08) c. Sexual Offender Registry; (3-26-08) d. Office of Inspector General List of Excluded Individuals and Entities; and (3-26-08) e. Nurse Aide Registry. (3-26-08) 03. Availability to Work. Any direct patient access	MM066	MM066 Refer to W 152 RECEIVED JUN 17 2009 FACILITY STANDARDS	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Admin. Designee — (X6) DATE: 6/12/09

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MM066	Continued From page 1 individual hired or contracted with on or after October 1, 2007, must self-disclose all arrests and convictions before having access to residents. The individual is allowed to only work under supervision until the criminal history and background check is completed. If a disqualifying crime as described in IDAPA 16.05.06, " Criminal History and Background Checks, " is disclosed, the individual cannot have access to any resident. (3-26-08) 04. Submission of Fingerprints. The individual's fingerprints must be submitted to the entity conducting the criminal history and background check within twenty-one (21) days of his date of hire. (3-26-08) 05. New Criminal History and Background Check. An individual must have a criminal history and background check when: (3-26-08) a. Accepting employment with a new employer; and (3-26-08) b. His last criminal history and background check was completed more than three (3) years prior to his date of hire. (3-26-08) 06. Use of Criminal History Check Within Three Years of Completion. Any employer may use a previous criminal history and background check obtained under these rules if: (3-26-08) a. The individual has received a criminal history and background check within three (3) years of his date of hire; (3-26-08) b. The employer has documentation of the criminal history and background check findings; (3-26-08) c. The employer completes a state-only background check of the individual through the	MM066		

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MM066	Continued From page 2 Idaho State Police Bureau of Criminal Identification, and (3-26-08) d. No disqualifying crimes are found. (3-26-08) 07. Employer Discretion. The new employer, at its discretion, may require an individual to complete a criminal history and background check at any time, even if the individual has received a criminal history and background check within the three (3) years of his date of hire. (3-26-08) This Rule is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure staff working with clients received fingerprint based criminal history and background check within 21 days of their hire date, which had the potential to negatively impact 6 of 6 individuals (Individuals #1 - #6) residing in the facility. That failure had the potential to allow staff to work at the facility without sufficient criminal history screening. The findings include: - Staff A's personnel file documented she was hired 2/20/09. Her personnel file contained two self declaration and applications for fingerprinting, dated 2/26/09 and 3/5/09. However, both self-declarations and applications were unsigned and un-notarized. Her filed did not include information that a background check had been completed within 21 days of her hire date. - Staff B's personnel file documented he was hired 1/13/09. However, his personnel file included an unsigned and un-notarized self	MM066		

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MM066	Continued From page 3 declaration and application for a background check. His filed did not include information that a background check had been completed within 21 days of his hire date. - Staff C's personnel file documented he was hired 11/25/08 and was terminated on 1/21/09. However, his personnel file included an unsigned and un-notarized self declaration and application for a background check. His filed did not include information that a background check had been completed within 21 days of his hire date. - Staff D's personnel file documented she was hired 2/11/09. Her file contained an application for a background check, dated 3/10/09, and a clearance letter was not received until 4/15/09. Her filed did not include information that a background check had been completed within 21 days of her hire date. - Staff E's personnel file documented he was hired 12/6/08. However, his personnel file did not include a self declaration and application for a background check. His filed did not include information that a background check had been completed within 21 days of his hire date. - Staff F's personnel file documented she was hired 3/1/09. However, her personnel file did not include a self declaration and application for background check. Her filed did not include information that a background check had been completed within 21 days of her hire date. During an interview on 5/21/09 from 9:30 a.m. - 12:30 p.m., the QMRP stated Staff A - F did not receive their background checks within the 21 day period after their hire dates.	MM066		

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MM066	Continued From page 4 The facility failed to ensure all staff completed the required background check within 21 days of their hire date.	MM066		
MM197	16.03.11.075.10(d) Written Plans Is described in written plans that are kept on file in the facility; and This Rule is not met as evidenced by: Refer to W312.	MM197	MM197 Refer to W 312	
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept clean, sanitary, and in good repair for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. The findings include: An environmental survey was conducted on 5/19/09 from 1:20 - 1:50 p.m., and the following concerns were noted: - The calking behind the kitchen sink was peeling. - The dehumidifier in the hall had a thick coat of dust on it.	MM380	MM380 1. All individuals have the potential to be affected by this practice. All employees are responsible for completing a damage report on all repairs that are needed in the facility. The damage report is then turned in to the supervisor for review. The supervisor then submits the damage report to the QMRP for follow-up. 2. All repairs that are needed will be completed by maintenance personnel. The graveyard deep cleaning list will be revised to incorporate dusting of the humidifier. 3. Target date for completion will be July 21, 2009.	

Bureau of Facility Standards

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MM380	Continued From page 5 - The center mounts of the hand rails by the front door were rusted through and detached. - Individual #6's bedroom wall had three holes to the right of the door.	MM380		
MM759	16.03.11.27.02(f)(v) Medication Error Any medication error must be reported immediately to the resident's attending physician and documented in the resident's record. This Rule is not met as evidenced by: Refer to W369 and W376.	MM759	MM759 Refer to W 369 and W 376	
MM769	16.03.11.270.03(c)(vi) Control of Communicable Diseases and Infectio Control of communicable diseases and infections through identification, assessment, reporting to medical authorities and implementation of appropriate protective and preventative measures. This Rule is not met as evidenced by: Refer to W455.	MM769	MM769 Refer to W 455	

Keep ē POC
for 5/21/09 survey

Addendum to Plan of Correction CMS-2567
Idaho Falls Group Homes
#3 Periska
05/21/2009

W 152

1. The employee will be required to complete the criminal history and background check application the day they are hired. The Home Supervisor will then schedule a background check for the employee on the next available appointment date on the day they are hired. The employee will not be allowed to work with any of the clients without supervision until the background check and fingerprints have been completed and a clearance letter has been received.

W 455

2. The QMRP will attend each facilities monthly staff meeting to ensure that supervisors are appropriately training on infection control practices, policies and procedures.

Administrator Signature: [signature] Date: 6-15-09